DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Date Issued: January 24, 2001

Operational Policy Letter #:OPL2001.131

To:	**Current M+C Organizations**	**X**
	CHPP Demonstrations:	
	Evercare	**X**
	DoD (TriCare)	**X**
	SHMO I & II	**X**
	PACE	**X**
	Medicare Choices	**X**
	OSP Demonstrations:	
	MSHO	**X**
	W.P.S.	**X**
	HCPPs	
	Federally Qualified HMOs	**X**
	Section 1876 Cost Plans	**X**

Subject: **Standard Reporting Requirements for Medicare Managed Care Organizations in 2001: Health Plan Employer Data and Information Set (HEDIS® 2001) Measures that Include the Medicare Health Outcomes Survey (HOS) and the Medicare Consumer Assessment of Health Plans Study (CAHPS® 2.0H)**

Effective Date: Upon publication

Implementation Date: January 1, 2001

Current Policy: Current policy is described in OPL #110. This OPL replaces and updates that OPL for the upcoming contract year 2001.

Important Changes from 2000

This OPL provides information regarding the 2001 Medicare HEDIS submission and provides clarification for Medicare contracting organizations under applicable law, regulations and contract requirements governing Medicare+Choice (M+C) organizations, the Section 1876 cost contracting organizations, and demonstration projects. Throughout this document, the general term, managed care organization (MCO), will be used to refer to all contracting organizations, unless otherwise specified.

This OPL replaces and supersedes OPL 99.110, issued December 22, 1999, which provided instructions for the HEDIS 2000 submission. With the exception of the geographic reporting unit, most of the reporting requirements and polices in place for HEDIS 2000 remain the same for HEDIS 2001. Changes are highlighted below. Please review the entire document thoroughly.

- Measures required to be submitted:
  Review Attachment I for the specific list of required measures. NCQA retired several measures for HEDIS 2001, including Rate Trends, High-Occurrence/High-Cost DRGs, Disenrollment, and Indicators of Financial Stability. However, HCFA did not require these measures to be submitted for HEDIS 2000 so the retirement of these measures will not change the reporting requirements from last year. Furthermore, HCFA does collect similar data through other means.

- New measures:
  NCQA identifies in HEDIS 2001, Volume 2: Technical Specifications and HEDIS 2001, Volume 3, Specifications for Survey Measures, one new measure, "Pneumonia Vaccination Status for Older Adults." This measure is collected annually through the Medicare CAHPS survey and is not a new measure for HCFA.

- Reporting Unit:
  After much research and deliberation, HCFA has changed the reporting unit requirement for HEDIS 2001. The new reporting unit will enable consistency among HEDIS, HOS, and CAHPS, will be less burdensome to MCOs due to fewer reporting units per organization, and will enable comparisons with Original Medicare Fee-For-Service, while accommodating other contract requirements, such as QISMC. (See the discussion in I.B.3). Letters will not be mailed to each MCO detailing their reporting unit for HEDIS 2001. MCOs should check "HEDIS 2001 Reporting Requirements" on the Medicare Managed Care Home Page on www.hcfa.gov for the specific required reporting unit(s).

- Submission deadline:
  The same policy as last year remains in place, which is that the Medicare HEDIS is due two weeks following the submission deadline for commercial HEDIS. Therefore, the Medicare HEDIS submission, both summary data and patient-level data is due June 29, the last business day in June.

- Enhancements to the Data Submission Tool (DST) and submission process for summary level data:
  NCQA is implementing a web-based validation and submission process for HEDIS 2001 summary data that should eliminate the need for submitting diskettes. This process will be described in instructions furnished by NCQA. Patient-level data files may not be submitted via the Internet.

Background

Effective January 1, 1997, HCFA began requiring MCOs to report on performance measures from the HEDIS® reporting set relevant to the Medicare managed care population, and to participate both in CAHPS® and the Health Outcomes Survey (HOS). This OPL explains reporting requirements for HEDIS 2001, HOS, and CAHPS and addresses specific HCFA requirements regarding how MCOs must implement HEDIS 2001, HOS, and CAHPS. CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

These requirements are consistent with the law and with the requirements of other large purchasers. It is critical to HCFA's mission that it collect and disseminate information that will help beneficiaries choose among MCOs and contribute to better health care through identification of quality improvement opportunities.

HCFA makes summary, plan-level performance measures available to the public through media that are beneficiary oriented, such as the Medicare Health Plan Compare Internet site (www.medicare.gov) and the *Medicare & You* handbook. A subset of HEDIS and CAHPS data is also available in printed form through a toll free line (1-800-MEDICARE). Disenrollment rates are also available in printed form through the same toll free line. HEDIS summary-level data files will be available through HCFA's Internet website as a Public Use File (www.hcfa.gov). The HEDIS, CAHPS, and Disenrollment Survey patient-level files will be available at cost to requesters authorized to receive such information. Requesters, for confidentiality reasons, must sign a Data Use Agreement with HCFA and must meet HCFA's data policies and procedures that include, but are not limited to, submitting a research protocol and study purpose. For information about Data Use Agreements, contact the Division of Data Liaison and Distribution, Enterprise Database Group, within HCFA's Office of Information Services.

PROGRAM REQUIREMENTS

2001 Contract year	Sampling Frame/ Period	Dates for Participation Eligibility	Minimum Sample Size	Market Area Reporting	Financial Responsibility	Demon-strations	Mergers and Acquisitions	Cost Contract Reporting	Due Dates
HEDIS 2001 and HEDIS 2001 audit	Services delivered in 2000 (and earlier for some measures)	First Medicare Enrollment on 1/1/00 or earlier Minimum Medicare enrollment of 1,000 as of 7/1/00	Measure specific (MCOs must report all HCFA-required Medicare measures according to instructions)	Yes	MCO pays for external HEDIS Audit	Yes, as specified in section I.C.10 below	Reporting by surviving MCO only	Report Cost Contract Measures Only	MCO must submit Audited Summary and Patient-Level Data by June 29, 2001.
Health Outcomes Survey	Members continuously enrolled 6 months prior to administration of survey	Medicare contract in place no later than 1/1/00	1000 (If less than 1000 enrollees, all members must be surveyed.)	Yes	MCO pays for NCQA-certified vendor to administer survey	Yes (See section I.C.10)	Reporting of surviving MCO's membership only	Yes	MCO must contract with NCQA-certified vendor before 2/1/2001
CAHPS	Members continuously enrolled 6 months prior to administration of survey	Medicare contract in place no later than 7/1/00	600 (If less than 600 enrollees, all members will be surveyed.)	Yes	HCFA pays for survey administration	Yes (See section I.C.10)	Reporting of surviving MCO's membership only	Yes	HCFA will administer survey in Fall 2001.

Implementing HEDIS 2001 Measures And Medicare CAHPS

I. Specifics Applicable to CAHPS and HEDIS

A. Effects of the Balanced Budget Act of 1997

The Balanced Budget Act of 1997 established Part C of Medicare, known as the M+C program which replaced the section 1876 program of risk and cost contracting starting with contracts effective January 1, 2000. The reporting requirements contained in this OPL apply to organizations that hold an M+C contract, a section 1876 cost contract, or a demonstration contract, in accordance with applicable law, regulations, and contract requirements. Please see section C below for exceptions to this requirement, such as organizations that have terminated their M+C contract or section 1876 contract with HCFA for 2001.

B. Requirements for MCOs

1. Reporting Requirements

a. HEDIS 2001: A MCO must report HEDIS 2001 measures for their Medicare managed care contract(s), as detailed in the HEDIS 2001 Volume 2: Technical Specifications if all of the following criteria are met:

- the contract was in effect on 1/1/00 or earlier;
- the contract had initial enrollment on 1/1/00 or earlier;
- contract had an enrollment of 1,000 or more on 7/1/00;
- the contract has not been terminated on or before 1/1/01.

The HEDIS technical specifications are updated annually. MCOs preparing HEDIS 2001 data submissions must follow instructions in HEDIS 2001, Volume 2 and the HEDIS 2001, Volume 2 Update (released October 2000). Please note that where there are differences between this policy letter and HEDIS 2001 Volume 2, this OPL takes precedence for reporting data. The final HEDIS 2001 Volume 2: Technical Specifications is available from NCQA. Please call NCQA Publications at 1-800-839-6487 to obtain a copy. The HEDIS 2001 Volume 2 update was released October 20. With this update, HEDIS 2001 specifications are frozen. MCOs are required to take into account the update. You may wish to check periodically the HEDIS Data Submission section of NCQA's website to review Frequently Asked Questions (FAQs).

The Medicare relevant measures in HEDIS 2001 that M+C MCOs must report are listed in Attachment I, and the Medicare relevant measures in HEDIS 2001 that continuing cost contractors must report are listed in Attachment I.A. Please note that two measures in the Health Plan Descriptive Information Domain (that are listed as Medicare) are not required to be submitted to HCFA: Practitioner Compensation and Arrangements with Public Health, Educational and Social Service Organizations.

b. Health Outcomes Survey (HOS): All MCOs that had a Medicare contract in effect on or before January 1, 2000 must comply with the HOS requirements during 2001. See the chart at C.10. for specific requirements for demonstration projects.

c. Medicare CAHPS: All MCOs that had a Medicare contract in effect on or before July 1, 2000, must comply with the CAHPS survey requirements during 2001. Medicare CAHPS does not apply to MCOs that received a contract effective after July 1, 2000. However, such MCOs may be required to undertake an enrollee satisfaction survey during 2001 to comply with the HCFA regulations on physician incentive plans (Vol. 61, Federal Register, 13430, March 27, 1996). MCOs may wish to use Medicare CAHPS for this purpose.

2. Minimum Size Requirements: This year there remains a minimum size requirement for MCOs to report HEDIS 2001 measures; MCO enrollment must be 1,000 or more on 7/1/00. In reviewing previous HEDIS submissions, HCFA noted that this is the enrollment level at which most MCOs could submit valid data on the Effectiveness of Care measures. There is no minimum size requirement to participate in the HOS and Medicare CAHPS surveys. When an MCO has fewer beneficiaries enrolled than the CAHPS sample size of 600 or the HOS sample size of 1,000, at the time the sample is drawn, the entire membership must be surveyed.

An MCO must report all the HCFA-required Medicare HEDIS measures, even if the MCO has small numbers for the denominator of a measure. For specific instructions on how to handle small numbers, review the Specific Guidelines in the HEDIS 2001 Volume 2, Technical Specifications. For information regarding the audit designation for these measures review HEDIS 2001 Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures.

3. Sampling and Reporting Unit: The Sampling and Reporting Unit has been changed for HEDIS 2001.

In prior years, MCOs reported once for each contract "H" number unless HCFA divided the contract service area into "market areas" where the contract service area covered more than one major community or city and each market area had at least 5,000 Medicare enrollees. Reporting units were known as "contract-markets." Due to the changes in an MCO's contract service area from year to year and other factors, this market area approach to reporting was not a completely stable unit for longitudinal analysis nor was it completely comparable within a contract year across MCOs in an area. The Balanced Budget Act and ensuing regulations and policy have significantly impacted the service area configurations of MCOs such that MCOs have consolidated multiple noncontiguous contracts within a state for the 2001 contract year. In addition, the BBA requires HCFA to report comparative quality and satisfaction information for managed care and fee-for-service in a manner not previously required.

Thus, after extensive analysis and deliberation among all the components that collect and utilize quality and satisfaction data from MCOs, the sampling and reporting units have been changed. In most states, MCOs will have one reporting unit. In five States, MCOs will have no more than two reporting units for HEDIS and HOS. The background on the change follows; after that is a summary of what each MCO must do to identify its reporting unit for 2001.

Medicare CAHPS has instituted a redesigned sampling unit for the Enrollee Survey and the Assessment Disenrollment Survey to accommodate comparison with Medicare CAHPS FFS and to retain the collection of satisfaction data at a local level. This sampling unit was used in the September 2000 fielding of the CAHPS survey. The number of units exceeds the number of "contract-market" units that had been in place during prior years but were capped at five per organization .

Medicare CAHPS data, regardless of how many sampling units are involved, will be rolled up into one State-level unit for display in the Medicare Handbook except in the case of the following 5 States: Florida, Ohio, New York, California, and Texas. In these states, the collected data will be aggregated into two display units for each State, generally labeled North & South or East & West. On the Medicare Health Plan Compare website, the user will see the same display unit for CAHPS. However, one can "drill down" to the level of the CAHPS sampling unit for more localized information. The sampling unit is a combination of counties combined into Health Service Areas (HSAs) which is a standard measure of health services utilization, determined by the Department of Health and Human Services.

For purposes of MCO accountability (contracting & purchasing) and quality improvement, we determined that the HEDIS data and the HOS data be collected, reported, and displayed at the level of the CAHPS Medicare Handbook "display" unit. That is to say, for MCOs doing business in a state, the unit will be all of the business in that state, associated with one H# , except for the five States noted above. In these five States that are divided in the Handbook (sub State segments), the MCOs will need to collect, report, and display HEDIS & HOS using the sub State segment counties. For most MCOs in 2001 this will result in one collection, reporting, and display unit only for HEDIS and HOS. In prior years, MCOs often had multiple units due to either 1) noncontiguous H# contracts or 2) HCFA subdivided market areas within an H# contract area. Some MCOs did not consolidate their noncontiguous areas for 2001 and will continue to have more than one reporting unit.

We believe that using the "display" unit as the HEDIS and HOS data collection, reporting, and display unit has the following advantages: simplicity, consistency among MCOs, improved consistency from year to year, consistency with CAHPS in consumer information displays, less burden and cost for MCOs who pay for HEDIS & HOS, and consistency with QISMC accountability which is at the MCO level.

However, we recognize that in some cases MCOs have reasons for reporting HEDIS data in other configurations, for example those MCOs who seek NCQA accreditation for their Medicare product line. On a case by case basis HCFA will evaluate the accreditable entities for the MCOs to see if we can accommodate MCOs to submit one HEDIS DST and, if they are accredited in a State in more than one unit, to use the accreditation units if feasible. We will need to ensure that a sub State segment has sufficient enrollment to produce HEDIS and HOS. In prior years for HEDIS and HOS we did not sub-divide a contract service area into market areas unless each market area had at least 5,000 enrollees. We will continue to use that threshold. While this collection and reporting at a higher level may mask some performance

variation at a lower level, we believe that it is not feasible to collect at a lower level due to small numbers, especially for the HEDIS Effectiveness of Care measures. Furthermore, using the HEDIS patient-level detail files, we can do an analysis of performance by re-constructing rates extrapolated from the summary data for other geographic areas within a State.

To identify what geographic area should be contained in the MCO's HEDIS reporting unit, the MCO must review the HEDIS 2001 Reporting Requirements site on the Medicare Managed Care Home Page on www.hcfa.gov. Note that the reporting will be based on the membership in the service area in place in Contract Year 2000 while the reporting entity will reflect the contract or entity structure under the Contract Year 2001 configuration. If you have a concern or question regarding the area specified for HEDIS contact: Patricia MacTaggart, Center for Health Plans and Providers, at (410) 786-1285. We will address each request on a case-by-case basis.

The steps HCFA will employ to delineate the HEDIS and HOS reporting units are:

1. Identify MCOs who will be continuing to hold contracts in 2001.
2. Identify the total Medicare contract service area associated with the post-consolidation H# of the MCO.
3. Identify the Medicare contract service area associated with the business area for the measurement year (2000).
4. Specify a reporting unit, by county names, that is either one area in a State or, in the case of
   MCOs in Florida, Ohio, New York, California, and Texas, may be either one or two reporting units.
5. Post the reporting units on www.hcfa.gov.

C. MCOs with Special Circumstances

1. MCOs with Multiple Contracts: A MCO cannot combine small contracts into a larger reporting unit. An MCO with multiple Medicare contracts must report HEDIS 2001, CAHPS, and HOS surveys for each risk and cost contract held in 2000. MCOs can check their reporting units on the hcfa.gov website.

2. MCOs Carrying Cost or HCPP Members: HEDIS performance measures will be calculated using only the Medicare enrollment in the M+C contract or the section 1876 contract in effect at year end 2000. Therefore, the following beneficiaries should not be included in HEDIS calculations.

   (1) any residual cost-based enrollees of a M+C contract
   (2) any residual HCPP enrollees of a section 1876 cost contract
   (3) any enrollees of a section 1876 cost contract, operated by an MCO with an active M+C contract, that was an HCPP in the prior contract year and is not open for enrollment.

For HEDIS measures with a continuous enrollment requirement and for enrollees who converted from one type of contract to another (with the same organization), enrollment time under the prior contract will not be counted.

3. MCOs with New Members "Aging-in" from their Commercial Product line: MCOs with members "aging into" their Medicare product line from their commercial product line must consider those members eligible for performance measure calculations assuming that they meet any continuous enrollment requirements. That is, plan members that switch from a MCO's commercial product line to the MCO's Medicare product line are considered continuously enrolled. Please read the General Guidelines of HEDIS 2001 Volume 2: Technical Specifications for a discussion of "age-ins" and continuous enrollment requirements.

4. MCOs with Changes in Service Areas: MCOs that received approval for a service area expansion during the 2000 contract year and those that will be reducing their service area effective January 1, 2001 must include information regarding those beneficiaries in the expanding or reducing areas based on the continuous enrollment requirement and use of service provisions of the particular measure being reported.

5. HMOs with Home and Host Plans: The home plan must report the data related to services received by its members when out of the plan's service area. As part of the Visitor Program/Affiliate Option (portability), the host plan is treated as another health care provider under the home plan's contract with HCFA. The home plan is responsible for assuring that the host plan fulfills the home plan's obligations. Plan members that alternate between an MCO's visitor plan and the home plan are considered continuously enrolled in the plan.

6. New Contractors and Contractors below the minimum enrollment threshold: MCOs with initial enrollment on February 1, 2000 or later will not report HEDIS 2001 performance measures for calendar year (CY)2000. In addition, MCOs with enrollment below 1,000 on July 1, 2000 will not be required to submit HEDIS 2001. Therefore, MCOs with Medicare enrollment below 1,000 on July 1, 2000 will not receive a data submission tool (DST). However, these plans must have systems in place to collect performance measurement information so that they can provide reliable and valid HEDIS data in 2002.

7. Non-renewing/Terminating MCOs: Entities that meet the HEDIS reporting requirements stated above but which have terminated contracts effective January 1, 2001 will not be required to submit HEDIS data in 2001 for CY 2000 or participate in the HOS survey. These contracts are required to participate in the CAHPS surveys in the Fall of 2000; however, they are not required to submit telephone numbers for telephone follow-up of nonrespondents.

8. MCOs with Continuing Section 1876 Cost Contracts: For cost contracts, HCFA has modified the HEDIS measures to be reported. Cost contractors will not report the Use of Services inpatient measures. The measures to be reported are listed on Attachment I.A. HCFA does not require cost contractors to report inpatient (e.g., hospitals, SNFs) measures because MCOs with cost-based contracts are not always responsible for coverage of the inpatient stays of their members. Cost members can choose to obtain care outside of the plan without

authorization from the MCO. Thus, HCFA and the public would not know to what degree the data for these measures are complete.

Cost contracts will provide patient-level data for all the HEDIS Effectiveness of Care and the Use of Services measures for which they submit summary level data. (See Attachment I.A.)

9. Mergers and Acquisitions: HCFA has determined that the entity surviving a merger or acquisition shall report both summary and patient-level HEDIS data only for the enrollment of the surviving company. Previously, HCFA required MCOs to report the Effectiveness of Care data for the members of the non-surviving contract; this reporting by the surviving entity applied if the non-surviving contract was in effect for any part of the measurement year. We determined that the difficulties of securing valid data for that population outweigh the utility of receiving it and deleted that requirement for HEDIS 2000; the policy remains for HEDIS 2001.

We recognize that a separate set of beneficiaries and affiliated providers may be associated with the surviving entity's contract. However, HCFA believes that HEDIS measures based on the combined 2000 membership and providers of both contracts could be misleading since the management, systems, and quality improvement interventions related to the non-surviving contract are no longer in place. Reported results based on combined contracts may not reflect the quality of care or medical management available under the surviving contract. The surviving contract(s) must comply with all aspects of this OPL for all members it had in 2000.

10. Demonstration Projects: HCFA also requires demonstration projects to meet the HEDIS, CAHPS and HOS reporting requirements, in accordance with applicable law, regulations, and contract requirements. All types of demonstration projects will be expected to comply with all the HEDIS reporting and audit requirements in this OPL. Specific waivers contained in the demonstration contracts may have been negotiated with HCFA and take precedence over any requirements specified in this OPL. For further information on the requirements for specific demonstrations, contact the HCFA project officer.

Demonstration	HEDIS 2001	HEDIS Audit	CAHPS	HOS
Social HMOs	Yes	Yes	Yes	Yes
Medicare Choices	Yes	Yes	Yes	Yes
Minnesota Senior Health Options	Yes	Yes	No	No
Wisconsin Partnership Program	Yes	Yes	No	No
Evercare	No	No	No	No
PACE	No	No	No	Yes
DOD Subvention	Yes	Yes	No	Yes

D. Implications for Failure to Comply

HCFA expects full compliance with the requirements of this OPL. MCOs must meet the time lines, provide the required data, and give assurances that the data are accurate and audited. In addition, many of the HEDIS requirements described in this OPL will be reviewed as part of HCFA's Contractor Performance Monitoring System.

E. Use of Data

Data reported to HCFA under this requirement will be used in a variety of ways. The primary audience for the HEDIS, CAHPS, HOS, and Disenrollment summary data is the Medicare beneficiary. These data will provide comparative information on contracts to beneficiaries to assist them in choosing among contracts. In addition, HCFA expects MCOs to use the data for internal quality improvement. The data should help MCOs identify some of the areas where their quality improvement efforts need to be targeted and may be used as the baseline data for Quality Assessment and Performance Improvement (QAPI) projects. Further, the data will provide HCFA with information useful for monitoring the quality of, and access to, care provided by MCOs. HCFA may target areas that warrant further review based on the data.

II. HEDIS 2001 Requirements

A. Summary and Patient-Level Data

HCFA is committed to assuring the validity of the summary data collected, before it is released to the public, and to make the data available in a timely manner for beneficiary information.

MCOs must submit HEDIS 2001 summary measures after completing the NCQA HEDIS Compliance Audit™ required by Medicare by June 29, 2001. MCOs must submit HEDIS patient-level data by June 29, 2001. HCFA is requiring the submission of patient-level data on the same date as summary data to ensure that the patient-level data matches the summary data. Please note that auditors will review patient-level data for the numerator and denominator of audited measures when checking for algorithmic compliance during the HEDIS audit. Both data files are to be submitted directly to NCQA.

1. Summary Data

a) Required Measures: MCOs that held M+C contracts in 2000 and meet the criteria in section C (1) of this OPL must report summary data for all required HEDIS 2001 measures identified in Attachment I, except for the Health Outcomes Survey measure (see discussion below at III). M+C MCOs that held section 1876 cost contracts and continuing open cost contracts must report summary data for all HEDIS 2001 measures identified in Attachment IA.

The HEDIS measures Flu Shots for Older Adults, Pneumonia Vaccination Status for Older Adults, and Advising Smokers to Quit are collected through the CAHPS survey instrument.

MCOs must attempt to produce every Medicare required measure, and report a numerator and denominator even if the numbers are small, i.e. the denominator is less than 30.

b) Data Submission:

NCQA will send MCOs the HEDIS 2001 Data Submission Tool© (DST) in April 2001. MCOs must submit HEDIS results for the 2000 measurement year using this tool and should make sure that they have sufficient computing capability to run the DST. The tool is the same Microsoft Excel®-based application used in 2000, modified to reflect changes in the HEDIS 2001 specifications. NCQA will provide more information regarding the tool and the submission process to MCOs.

As in previous years, MCOs will not be allowed to change their data after submission to NCQA. The upgraded DST will allow MCOs to print a hard copy of the DST and to review all rates with their auditor prior to submission.

2. Patient-Level Data

Analysis of data with patient-level identifiers for the numerator and denominator of each measure allows HCFA to match HEDIS data to other patient-level data for special projects of national interest and research, such as an assessment of whether certain groups (e.g. ethnic, racial, gender, geographic) are receiving fewer or more services than others. These analyses will not be used for public plan-to-plan comparisons.

(a) Required Measures: MCOs must provide patient-level data identifying the contribution of each beneficiary to the denominator and numerator of every required summary measure on

beneficiaries and each beneficiary's months of enrollment. Attachment II lists the clinical Effectiveness of Care process measures (excluding the Health Outcomes Survey measure) and the Use of Services measures for which patient identifiers and member month contributions must be provided. Beneficiaries shall be identified by their individual health insurance claim (HIC) number. The HIC number is the number assigned by HCFA to the beneficiary when he/she signs up for Medicare. MCOs use this number for enrollment accretions/deletions.

(b) Data Submission: NCQA expects to continue collecting patient-level data as a flat text file and will provide MCOs with the record layout and detailed examples in spring of 2001. Plans must retain data used for reporting for three years.

All patient-level data are protected from public dissemination in accordance with the Privacy Act of 1974, as amended. There have been questions and concerns expressed about the provision of patient-level data, particularly with regard to behavioral health measures. Plans are accountable for providing patient-level data, unless prohibited by state law. In such cases, plans must provide HCFA with appropriate documentation of the legal prohibition for HCFA's consideration.

B. HEDIS Audit Requirements

Because of the critical importance of ensuring accurate data, HCFA continues to require an external audit of the HEDIS measures before public reporting. MCOs are responsible for submitting audited data, according to the "Full Audit" methodology outlined in HEDIS 2001, Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures.

HCFA requires each MCO to contract with an NCQA licensed organization for a NCQA HEDIS Compliance Audit and should do so in a way that will coordinate the audit process for all sources. The licensed audit firms are listed on NCQA’s web site at www.ncqa.org. HCFA will require that the licensed organizations use the NCQA HEDIS 2001, Volume 5. The Full Audit is described within this reference document. The health plan must ensure that the site visit audit team is led by a NCQA certified HEDIS Compliance Auditor and that the auditor is present during the site visit.

In addition, the plan’s chief executive officer , president, or other authorized person, such as the medical director, will be required to provide written attestation to the validity of the plan-generated data.

3. Final Audit Reports, Use and Release

Following the receipt by the MCO of the Final Audit Report from the NCQA-licensed audit firm, the MCO must make available a copy of the complete final report as described in HEDIS 2001 Volume 5, Chapter 7, to the HCFA Regional Offices as needed. HCFA Regional Offices may request the report upon completion or they may request it as part of the pre-site visit package. In addition, the report should be available for review onsite during the visit.

HCFA will use the Final Audit Reports to support contract monitoring and quality improvement activities. HCFA may use the assessment of the MCO's administrative and information systems capabilities that are contained in the audit report and may use the data to conduct post-submission validation. Final Audit Reports are subject to the Freedom of Information Act (FOIA). HCFA will follow the FOIA regarding any release of such report and will make a determination about the release of information in each audit report on a case by case basis. Information that both the MCO and HCFA deem proprietary will not be released, unless otherwise required by applicable law.

III. The Medicare Health Outcomes Survey (HOS) Requirements

The Short Form (SF) 36 supplemented with additional case-mix adjustment variables will be used to solicit self-reported information from a sample of Medicare beneficiaries for the HEDIS 2001 functional status measure, Medicare Health Outcomes Survey (HOS). This measure is the first "outcomes" measure for the Medicare population. Because it measures outcomes rather than the process of care, it is primarily intended for population-based comparison purposes, by reporting unit. The HOS measure is not a substitute for assessment tools that MCOs are currently using for clinical quality improvement. In 2001 cohort 4 baseline will be drawn. As in prior years 1,000 beneficiaries per reporting unit will be surveyed. The target response rate is at least 70 percent. If the contract-market has fewer than 1,000 eligible members, all will be surveyed.

Additionally, in 2001 the cohort two baseline respondents (originally surveyed in 1999) will be resurveyed. The results of this remeasurement will be used to calculate a change score for the physical health and emotional well being of each respondent. Depending on the amount of change the respondent will be categorized as having improved, declined, or as having undergone no change in health status over the two year period. Percentages of respondents whose health status improved, declined, and remained the same by plan will be released publicly in spring 2002.

All M+C MCOs and continuing cost contracts that held section 1876 risk and cost contracts in 2000, as well as Social HMOs (SHMOs), PACE, and Medicare Choices demonstrations, with Medicare contracts in effect on or before January 1, 2000 must comply with this survey requirement during 2001.

MCOs, at their expense, are expected to contract with any of the NCQA certified vendors for administration of the survey to both the new baseline cohort (cohort4) and the remeasurement of cohort two (if the MCO participated in the 1999 HOS baseline measurement).

You may begin contracting with vendors as soon as possible. Contracts are expected to be in place by February 1, 2001 to ensure survey implementation by mid-March, 2001. Further details will be provided by NCQA, HCFA's contractor, regarding organizing the survey.

To expedite the survey process, MCOs may be asked to provide telephone numbers or verify telephone numbers for the respondents unable to be identified using other means. MCOs must

ensure the integrity of the data files they provide to the vendors by checking for, among other things, shifted data fields or out of range values. MCOs will be financially liable for the cost of any re-work (including but not limited to readministration of the survey) and subsequent delay by the vendor resulting from corrupt data files transmitted to the vendor by the MCO.

Since the Health Outcomes Survey measure looks at health status over a two-year period, results from the cohort 4 baseline survey will not be publicly released in 2001. The follow up survey in 2003 will assess the same beneficiaries' health status compared to two years prior. Beneficiaries will be categorized into those who are better, the same, or worse over the two year period. Each reporting unit score (the percent of beneficiaries who are better, the same or worse), will be reported in spring 2002 for the cohort two follow up and in spring 2004 for the cohort 4 follow up survey. See Attachment III for additional information.

IV. Medicare CAHPS Requirements for Enrollees and Disenrollees

A. Update on Round 3 of the 1999 Medicare CAHPS Enrollee Survey

All section 1876 risk and cost MCOs whose Medicare contracts were in effect on or before July 1, 1998 were required to participate in this administration of the Medicare CAHPS survey. For the third round, the Medicare Managed Care CAHPS survey was administered for all eligible Medicare contract-markets by a single independent contractor. The response rate was 82 percent.

Selected results from this survey were released to the public to facilitate plan-to-plan comparisons. Only data gathered through HCFA's administration were publicly released. These data are being disseminated to the public via Medicare Health Plan Compare (www.medicare.gov), 1-800-MEDICARE, as well as with the Medicare & You 2001 mailout.

In June 2000, HCFA provided the MCOs participating in the HCFA administration of the CAHPS survey with detailed reports for their own internal quality improvement efforts, consistent with the Privacy Act (Title 5, USC, section 552a).

B. Information Regarding 2000 CAHPS Enrollee Survey

In the Fall of 2000, HCFA began to administer the fourth Medicare Managed Care CAHPS survey. M+C MCOs and continuing cost contracts with contracts in effect on or before July 1, 1999 are included. MCOs that will terminate their contracts as of January 1, 2001 are included in this administration; however, these MCOs do not have to provide telephone numbers for the telephone follow-up of nonrespondents. HCFA selected the sample for each contract-market. Each sample included a random sample of 600 members who had been continuously enrolled in the contract for six months and were not institutionalized. As stated earlier in the OPL, the sampling unit has been modified for the CAHPS survey to facilitate comparisons with fee-for-service. If you have any questions about the sampling units, please send questions to CAHPS@HCFA.gov. For MCOs with fewer than 600 eligible members, all eligible members were surveyed. The survey administration mode for the fourth round is identical to that of previous rounds: two mailings with telephone follow-up of non-respondents. To conduct the

telephone follow-up of non-respondents in September 2000, we requested telephone numbers from MCOs for the CAHPS sample embedded within a larger list of beneficiaries enrolled in the MCO. **HCFA is paying for the administration of the survey.**

Selected results from this survey will be released to the public to facilitate plan-to-plan comparisons. Only data gathered through HCFA's administration will be publicly released. These data will be disseminated to the public via Medicare Health Plan Compare (www.medicare.gov), 1-800-MEDICARE, as well as with the *Medicare & You 2002* mailout.

In June 2001 HCFA will provide the MCOs participating in the HCFA administration of the CAHPS survey with detailed reports for their own internal quality improvement efforts, consistent with the Privacy Act (Title 5, USC, section 552a).

C. Information Regarding 2001 CAHPS Enrollee Survey

In the Fall of 2001, HCFA plans to administer the fifth Medicare Managed Care CAHPS survey. M+C MCOs and continuing cost contracts with contracts in effect on or before July 1, 2000 will be included. **HCFA is planning on paying for the administration of the survey.**

D. Information Regarding 2000 CAHPS Disenrollment Survey

HCFA began nationwide administration of the Medicare CAHPS (Consumer Assessment of Health Plans Study) Disenrollment Survey in Spring 2000 for all M+C contracts, continuing cost contracts, and selected demonstrations. A single independent contractor is conducting the survey under the direction of HCFA. Similar to the enrollee survey, survey administration consists of two mail surveys with telephone followup of nonrespondents.

The Medicare CAHPS Disenrollment Survey has two distinct components. The first asks beneficiaries about their reasons for leaving a M+C contract and is called the Reasons Disenrollment Survey. HCFA will pair reasons for disenrolling with annual disenrollment rates for reporting to beneficiaries. HCFA is administering this component of the survey on a quarterly basis. The second component called the Assessment Disenrollment Survey includes almost all of the same questions as those in the Medicare Managed Care CAHPS Survey of enrollees. The information from this component will be combined with the results of the enrollee survey to create a more complete picture of beneficiary experiences with Medicare managed care. HCFA is going to administer this component of the survey on an annual basis. **HCFA will pay for the administration of these surveys.** Like the CAHPS Enrollee Survey, each managed care organization will be asked to provide HCFA's contractor with telephone numbers for former enrollees to be used for telephone followup of nonrespondents.

The Reasons Disenrollment Survey began in May 2000. For the 2000 administration, HCFA is including contracts that have been in affect on or before January 1, 1999. Sampling is done at the contract level. HCFA is administering the survey to a total annual sample of approximately 300 beneficiaries per contract. For those contracts with less than 300 disenrollees, HCFA is surveying all disenrollees, after accommodating allocation of some sample to the Assessment

Disenrollment Survey. The sample will include beneficiaries who disenroll from their contract during calendar year 2000 and who are not institutionalized. The survey sample will not include beneficiaries who have died, who have lost their Medicare eligibility, whose contracts have terminated completely or in a specific zip code, or who have moved out of the contracts' service areas. Summary information from the first two quarters of the survey will be disseminated to health plans during Winter 2001. Health plans will receive a report summarizing the first four quarters of data during Summer 2001.

The Assessment Disenrollment Survey will begin in October 2000. To be included in the survey, contracts have to be in effect on or before July 1, 1999. The sample size for this component is the proportion of the CAHPS Enrollee Survey sample (600) to total contract enrollment at the time the CAHPS sample is pulled in July 2000 multiplied by total 1999 disenrollment in the sampling area. HCFA pulled the sample at the end of August from the population of beneficiaries disenrolling in May, June, and July who are not institutionalized. The survey sample does not include beneficiaries who have died, who have lost their Medicare eligibility, or who have moved out of the contracts' service areas. Both the CAHPS Enrollee Survey and the Assessment Disenrollment Survey are using the same sampling units. Information from the Assessment Disenrollee Survey will be combined with the responses collected from CAHPS Enrollee Survey and will be included in the plan reports sent to health plans in Summer 2001.

E. Information Regarding 2001 CAHPS Disenrollee Survey

In the Spring of 2001, HCFA plans to begin administering on a quarterly basis the Disenrollment Reasons Survey. Contracts that have been in effect on or before 1/1/2000 will be included. In Fall 2001, HCFA plans on administering the Disenrollment Assessment Survey. Contracts in effect on or before July 1, 2000 will be included in the assessment survey. **HCFA is planning on paying for the administration of these surveys.**

Contacts:

1. HEDIS 2001 and HEDIS Audit: MCOs should address all questions or requests for clarifications about the HEDIS 2001 Technical Specifications to NCQA's technical information line (202) 955-5697 or E-mail hedis@ncqa.org.

Questions about Medicare HEDIS not resolved through NCQA can be directed to Patricia MacTaggart at (410) 786-1285 in HCFA's Center for Health Plans and Providers. When contacting HCFA, MCOs should be prepared to tell HCFA both the advice that they received from NCQA and the individual at NCQA with whom they spoke.

Questions about the HEDIS audit can be addressed by Dorothea Musgrave at (410) 786-1099 in HCFA's Office of Clinical Standards and Quality.

2. HOS: For technical questions regarding the Medicare Health Outcomes Survey, please contact Chris Haffer in HCFA's Office of Clinical Standards and Quality at (410) 786-8764.

Questions relating to the vendors or survey protocol should be addressed to Oanh Vuong at NCQA at (202) 955-1777.

3. CAHPS: For technical questions regarding Medicare CAHPS, please contact Amy Heller at (410) 786-9234 or Lori Teichman at (410) 786-6684 of HCFA's Center for Beneficiary Services or email CAHPS@HCFA.gov.

4. Demonstrations: For questions regarding policy and technical questions on the demonstration projects contact the assigned HCFA project officer.

This OPL was prepared by the Office of Clinical Standards and Quality in collaboration with the Center for Health Plans and Providers and the Center for Beneficiary Services.

Attachment I

HEDIS 2001 REQUIRED MEASURES FOR MEDICARE REPORTING FOR SUMMARY DATA

All HEDIS measures should be reported at the level identified for each specific MCO

Effectiveness of Care
- Antidepressant Medication Management (for those with a drug benefit)
- Cholesterol Management After Acute Cardiovascular Events
- Breast Cancer Screening
- Beta Blocker Treatment After A Heart Attack
- Comprehensive Diabetes Care
- Follow-up After Hospitalization for Mental Illness
- Controlling High Blood Pressure
- Medicare Health Outcomes Survey

Access to/Availability of Care
- Adults' Access to Preventive/Ambulatory Health Services
- Availability of Language Interpretation Services, Parts I & II

Health Plan Stability
- Years in Business/Total Membership
- Practitioner Turnover

Use of Services
- Frequency of Selected Procedures
- Inpatient Utilization - General Hospital/Acute Care
- Ambulatory Care
- Inpatient Utilization - Non-Acute Care
- Mental Health Utilization - Inpatient Discharges and Average Length of Stay
- Mental Health Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services
- Chemical Dependency Utilization - Inpatient Discharges and Average Length of Stay
- Chemical Dependency Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services
- Outpatient Drug Utilization (for those with a drug benefit)

Health Plan Descriptive Information
- Board Certification/Residency Completion
- Total Enrollment by Percentage
- Enrollment by Product Line (Member Years/Months)

REPORTING CLARIFICATIONS

The following HEDIS measures will not be required to be submitted for HEDIS 2001.

Health Plan Descriptive Information
- Practitioner Compensation
- Arrangements with Public Health, etc.

Attachment I.A

CONTINUING COST CONTRACTS: HEDIS 2001 REQUIRED MEASURES FOR MEDICARE REPORTING FOR SUMMARY DATA

All HEDIS measures should be reported at the level identified for each specific MCO

Effectiveness of Care
- Antidepressant Medication Management (for those with a drug benefit)
- Cholesterol Management After Acute Cardiovascular Events
- Breast Cancer Screening
- Beta Blocker Treatment After A Heart Attack
- Comprehensive Diabetes Care
- Follow-up After Hospitalization for Mental Illness
- Controlling High Blood Pressure
- Medicare Health Outcomes Survey

Access to/Availability of Care
- Adults' Access to Preventive/Ambulatory Health Services
- Availability of Language Interpretation Services, Parts I & II

Health Plan Stability
- Years in Business/Total Membership
- Practitioner Turnover

Use of Services
- Ambulatory Care
- Outpatient Drug Utilization (for those with a drug benefit)

Health Plan Descriptive Information
- Board Certification/Residency Completion
- Total Enrollment by Percentage
- Enrollment by Product Line (Member Years/Months)

Attachment II

SUBMITTING PATIENT-LEVEL DATA

Required Measures

MCOs must provide the patient identifier, or HIC number, for all beneficiaries included in the summary data. MCOs must submit patient-level data by reporting unit. The HIC number is assigned by HCFA to the beneficiary when s/he signs up for Medicare, and MCOs use this number for accretions and deletions. In addition to the patient identifier, MCOs also must provide the member month contribution for each beneficiary and indicate how each beneficiary contributed to the calculation of the following summary measures.

Note: Section 1876 cost contracts in 2000 (whether or not they convert to become an M+C MCO in 2001) should only report patient-level data for the summary measures that are listed in Attachment I.A for the following three domains.

Effectiveness of Care:

- Breast Cancer Screening
- Beta Blocker Treatment After A Heart Attack
- Comprehensive Diabetes Care
- Follow-up After Hospitalization for Mental Illness
- Antidepressant Medication Management
- Cholesterol Management After Acute Cardiovascular Events
- Controlling High Blood Pressure

Access/Availability of Care:

- Adults' Access to Preventive/Ambulatory Health Services

Use of Services:

- Frequency of Selected Procedures
- Inpatient Utilization - General Hospital/Acute Care
- Ambulatory Care
- Inpatient Utilization - Nonacute Care
- Mental Health Utilization- Inpatient Discharges and Average Length of Stay
- Mental Health Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services
- Chemical Dependency Utilization- Inpatient Discharges and Average Length of Stay
- Chemical Dependency Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services

To be useful, this patient-level data must match the summary data for the measures discussed here, i.e. the patient file should contain all beneficiaries enrolled in the contract at the time that the summary measures are calculated. To ensure an exact match, the MCO should make a copy, or "freeze," its database when the summary measures are calculated. NCQA will provide

MCOs with exact file specifications and explicit instructions by spring of 2001, which is sufficient time to allow MCOs to identify the best way to fulfill this requirement.

Attachment III

ADDITIONAL INFORMATION ON THE MEDICARE HEALTH OUTCOMES SURVEY

Data Feedback

Please remember that individual member level data will not be provided to plans after baseline data collection. However in 2001 you will receive the following from HCFA:

2000 HOS Plan Performance Profile - will be mailed to all plans participating in the 2000 HOS cohort three baseline. This quality improvement tool, which presents an aggregate overview of the baseline health status of your MCO's Medicare enrollees, was developed and extensively tested to ensure that MCOs would find the data useful and actionable. Accompanying the profile will be an information synthesis which provides insight into the types of interventions that show promise at improving functional status. Your state Peer Review Organization/Quality Improvement Organization will also receive copies of the performance profiles and stands ready to collaborate with you on interpreting the data, identifying opportunities to improve care, assisting you in planning effective, measurable interventions, and evaluating and monitoring the results of your interventions. Using data from the Health Outcomes Survey to plan and conduct a quality improvement project may fulfill one of the Quality Assessment and Performance Improvement requirements (QAPI) under QISMC. If you do not receive your performance profile by April 30 , 2001 please contact Health Services Advisory Group (HSAG) at 1-(888) 880-0077 or e-mail to azpro.hos@sdps.org. Each MCO receives one performance profile free of charge. Additional and replacement copies are available at cost from HSAG.

1999-2001 Cohort Two Member Level Data - These data sets will be prepared and released to plans as soon as the follow up data are thoroughly analyzed. We anticipate availability in Spring 2002.

Vendor Reports

The vendors administering the survey may provide you with reports on the progress of mail and telephone survey administration. Each report may consist of data on the number of surveys issued during the first and second survey mailings, the number of surveys returned completed or partially completed, the number of sampled members for whom a survey could not be obtained (e.g., due to death, disenrollment, language barrier), and mail and telephone response rate calculations.

Please DO NOT ask your vendor for additional analyses or member specific data. They are prohibited from providing this type of information.

Requests for interpretation of the data or more detailed analyses of the data should be directed to your state PRO/QIO.

2001 Health Outcomes Survey Conference

The next Medicare Health Outcomes Survey conference may be held in late spring or summer 2001. This conference will highlight results from cohort one, preliminary aggregate results from cohort three, as well as reports on MCO/PRO collaborations using Health Outcomes Survey data to improve the quality of care provided to Medicare beneficiaries. More information will be forthcoming.